216 The Sexual History

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The process of taking a useful and accurate sexual history is sufficiently threatening to most clinicians to justify some special comment. It is easy for the physician to excuse the omission of a sexual history on any one of several grounds:

- I'm in a hurry.
- It isn't pertinent to this patient's illness.
- The patient didn't mention any sexual complaint.
- I respect the patient's privacy whenever possible.
- If I ask sexual questions, the patient may think I'm a pervert or a nut.
- The patient might be embarrassed.
- I will next time.
- Her gynecologist takes care of that.

The real reasons are more often:

- I really don't know how to go about it.
- I'm always in a hurry and never take a very complete history.
- I never ask sexual questions.
- I forgot because I was more "interested in" (comfortable with) the other problem.
- If I asked and uncovered a problem, I wouldn't have any idea what to do about it.
- I would be embarrassed.
- I often forget that patients have sexual lives that are important to them.
- You can't send everyone to a psychiatrist.
- Nobody's sex life is perfect, my own included.

Taking a sexual history serves two functions. First, it may identify problem areas that justify active treatment. Second, it serves notice to the patient that the physician sees sexual function as an important and integral part of the medical history and lifestyle of the patient and demonstrates that the physician is ready and willing to discuss sexual problems in the future should the patient desire.

The patient views his or her sexual life and performance as private but very important. If an illness has had or is likely to have an impact on sexual feelings and activity, the patient wants to know the facts and understand them thoroughly. The patient's sexual partner is equally involved, concerned, and anxious for information.

Partner: Did you ask him how soon we could begin to make love?
Postoperative (or postcoronary) patient: He just said to take it easy for awhile.
Partner: What does that mean?
Postoperative patient: I don't know.

It is difficult to think of an illness that does not have an impact on sexual function, from tonsillitis ("How long will you be infectious?") to a broken foot ("I can't get on top with this cast on my leg.").

Often the patient's initial complaint is intended only as an introduction, which the patient hopes will lead to a more specific discussion of sexual problems.

Patient: I'm having pains in my stomach. (or, "I haven't been feeling well lately.")

When a physician deals with this initial complaint summarily or dismisses it as unimportant, the patient becomes confused and angry because the hoped-for gradual disclosure has been thwarted. If, however, a sexual function history becomes a routine part of data collection, then the patient has a nonthreatening opportunity to expand on the original complaint.

Like all other parts of the database, the type and complexity of the data collected vary according to the patient's problem. Familiarity with the various forms of human sexual inadequacy makes the physician sensitive to patient response and indicates directions for further questioning. Familiarity with normal sexual anatomy and physiology lends the physician a sense of confidence and assurance in dealing with sexually confused or dysfunctional patients.

Sexual Words

Words allow us to transfer complex ideas and experiences to another person rapidly. When a physician and a patient communicate, they must find some common or equally acceptable vocabulary if information, ideas, and feelings are to be exchanged effectively and comfortably. The following techniques are useful in dealing with sexual words.

- Never accept a sexual term at face value until you are sure what the patient means by it.

  Patient: I'm impotent.
  Physician: Do you mean that you have trouble getting an erection, have trouble keeping the erection long enough to use it, or something else? (Or, "What do you mean by that? What does the term 'impotent' mean to you?")

- Be sensitive and inquiring about the sort of terms with which the patient is comfortable. Keep a mental or written list. If it appears necessary to discuss sexual function at any length with the patient, it is permissible to ask directly about terms the patient and partner use together.

  Physician: When you and your husband are talking about his penis, his sexual organ, what do you call it?

- When your patient seems confused by terminology, it may be helpful to use several different terms in a series

to convey the idea. The terms selected are usually the least "loaded" words known.

Physician: Are you having any pain or discomfort in your vulva—your female organs—your privates?

- Once a patient has used a nonscientific but understandable sexual term, it is permissible for the physician to use the same term.

Patient: I really like it when he goes down on me.
Physician: Do you ever come—have an orgasm—when he goes down on you?

- Rarely and cautiously a physician may introduce common or slang terms into the conversation. This is more often done with younger patients and usually only when some mutual respect and rapport have been established between the patient and physician.

Physician: It seems to me you've been saying that there has been a lot of screwing in this marriage but not much loving.
Patient: That's right.

Too often, both physician and patient try to use the physician's vocabulary. This results in discomfort and confusion on the part of the patient who may be trying to use or understand unfamiliar or half-understood words. Communication is enhanced when the physician adapts to the patient, instead of vice versa. The effective physician must master many vocabularies and adjust his language to meet the communication needs of individual patients. This is part of the art of medicine rather than the science. It is as important a skill as surgical technique or differential diagnosis.

In American culture, sexual words are particularly difficult for patients and often for physicians as well. Instead of accepting them as simple tools for effective communication, all sorts of taboos and value judgments are made that inhibit the free use of sexual words. Words in common, everyday usage by some people are regarded as gross obscenities by others. Patients often feel that the words they know and use regularly will not be acceptable to a physician–father–authority figure. Patients, therefore, are often uncomfortable using their own words and are uncertain about the precise meaning of both scientific and other less familiar slang expressions. Many commonly used terms have multiple meanings. Some examples are:

- "Make out" may mean manual or oral foreplay in some contexts and sexual intercourse in others.
- "Go to bed" covers a range of activities from watching television to sleep to coitus.

Patients often use terms that they believe will earn approval from physicians. Many of these may be imperfectly understood or incorrectly used by the well-intentioned patient (e.g., "I have a pain in my vagina").

No words are inherently dirty, indecent, or immoral. Physicians should use sexual words with which patients are familiar and comfortable.

Problems in Sexual History Taking: Assumptions and Biases

In sexual history taking there is a grave risk that the examiner will assume too much about the patient from superficial clues or from the examiner's personal biases. Such assumptions put the examiner at a great disadvantage and confuse as well as embarrass the patient. The usual result of such assumptions is the loss of time, valuable information, and rapport with the patient. It is axiomatic that the examiner cannot be certain about *anything* concerning the patient's sexuality from a superficial examination of dress, manner, or style. Indeed, many patients' dress, manners, and style are deliberate or unconscious strategies to hide true sexual feelings and attitudes. It is best to approach all patients with a clean slate and allow them to express personal feelings and attitudes. Observations of dress, manners, or style coupled with history are extremely informative but must not distract the examiner from history taking.

The examiner's own biases may distract the direction of history taking. Common biases are:

- Young people aren't sexual yet.
- Old people aren't sexual anymore.
- Dignified, mature men and women can't be very concerned about their sexuality.
- Married people can't have venereal disease.
- "Nice" people don't enjoy sexual variations.
- Girls who dress sexy are sexy.
- Effeminate men are gay.
- You can always tell gay people by the way they act.
- Sick people aren't sexual.
- Blind, deaf, cerebral palsied, and paraplegic people aren't sexual.
- Women aren't gay.
- Women don't get horny.
- Nobody over 35 ever heard of fellatio and cunnilingus, much less tried them.
- My mother and father never had intercourse—or at least not often—or at least not anymore.
- If you are a woman, you must either want a man or already have a man.
- Patients never get sexually interested in their doctors.
- Doctors never get sexually interested in patients.
- Fat people aren't sexual.
- Ugly people aren't sexual.
- Retarded people aren't sexual.
- Black people are different from white people.
- Oriental people are probably different from black people and white people—at least they are inscrutable and polite.
- There are two kinds of women: the good kind, mothers and sisters, and the other kind.
- The world is pretty much the way I see it, and normal people are pretty much like me except that I am exceptional.

Acting from these or similar biases can erase much of the effectiveness of any history taker. All people have biases of some sort, determined by their learned concept of what the world is like. Setting aside biases is a conscious act requiring practice and at best can be only partial. For that reason, each history taker should begin with a clean slate.

Homosexuality

A sexual preference for partners of the same sex occurs in perhaps 10% of men and 5 to 6% of women. These statistics are not precisely accurate, since public attitudes toward homosexuality are often judgmental and punitive, and many

such individuals feel the need to conceal their sexual preference or at least not advertise it publicly. It is easier for homosexual women to live a life with a same-sex partner than it is for homosexual men to do so because our culture is tolerant or permissive when women share living quarters but tends to show anxiety when adult men live together.

Questions about homosexuality have not been a routine part of the survey-type history, but perhaps such inquiries should become so. In recent years we have begun to recognize rather striking differences in health risks among homosexual women and men when compared to a heterosexual population. Homosexual women, for example, have little need for contraception and are at a very low risk for venereal disease. Because carcinoma of the cervix is epidemiologically related to early initiation of sexual intercourse and to multiplicity of coital partners, exclusively homosexual women should have reduced risk of cervical cancer. Male homosexuals, in contrast, have a high risk of venereal disease, some increased risk of parasitic infestations, and are a prime risk group for AIDS, the acquired immune deficiency syndrome. Sadomasochistic behavior is somewhat more common in male homosexuals than the general population, and such individuals are perhaps more likely to present with foreign bodies or signs of genital or anal trauma.

The vast majority of homosexual men and women are not different in dress, grooming, voice, or mannerisms from heterosexual people, and in fact live very similar lives. One should not assume that superficial behavior or appearance rules in or out a preference for same-sex partners. It is useful to discard whatever stereotypes have been picked up and approach each patient with an open mind until some data reveal sexual preference. Many individuals who eventually accept their homosexual orientation may have gone through years of typical heterosexual activities previously. This includes heterosexual dating, marriage, coitus, child bearing and rearing. Some individuals may enjoy opportunities for both heterosexual and homosexual relationships and experiences. A few individuals, even though homosexual, may wish for parenting so strongly that they undertake to conceive a child or children and rear them.

Aside from straightforward health risks, the issue of homosexuality is likely to come to the physician's attention because of anxiety that has been created by one of several circumstances:

- An individual who has clear homosexual preferences has acute or chronic anxiety about his or her own acceptance of this feeling and about the problems of living as a maligned minority. The families of homosexual men or women may present with the same issues.
- Individuals who have had one or more same-sex sexual experiences may have anxiety about whether they are homosexual or not. One or several homosexual experiences do not mean that an individual is homosexual any more than one or several heterosexual experiences mean that an individual is heterosexual. In the Kinsey study of male sexuality more than 35% of all males had a sexual experience leading to orgasm with another male by age 25. Much of this behavior is childhood or adolescent experimentation. Most men and women have had dreams, fantasies, or experiences in which they were attracted to or admired same-sex individuals. Anxiety about the meaning of such experiences is common.
- Homosexual men and women have the same sorts of relationship issues and sexual dysfunctions that heterosexual people have. A homosexual male may complain of anxiety about penile size, performance anxiety, premature ejaculation, primary or secondary impotence, ejaculatory delay or incompetence, or loss of desire. A homosexual woman may be anorgasmic, have anxiety about body image, or have loss of desire. Vaginismus and dyspareunia are less common in homosexual women because sexual play less often involves vaginal penetration.

Male homosexual behavior has a greater emphasis on physical attractiveness and youth with many more transitory sexual partners ("cruising"), even though long-term relationships are relatively common. Female homosexual behavior has somewhat less emphasis on physical appearance than heterosexual, and a heavy emphasis on relationships. Less cruising behavior and more long-term relationships are common. Nurturing and mutually supportive behavior are often an important element in lesbian couples.

The term *gay* is generally accepted as common slang for male and/or female homosexual people and relationships. In addition, the term *lesbian* seems acceptable and nonjudgmental for female homosexuals and relationships. Almost all other terms are presently unacceptable to the homosexual community. Such terms as *queer, fag, pansy, queen, dyke,* or *bull dyke* refer to stereotypes which have little validity and should be avoided.

If in the course of history taking the physician is uncertain about the sexual orientation of the patient, relatively simple questions may clarify the problem: "Do you have a sexual partner now?" or "Is there someone in your life who is emotionally important to you now?" "Has there been in the past?" "Can you tell me something about that person?"

Many patients who have fears that they may be homosexual can be relieved and reassured by such questions as:

- Most boys and girls can remember playing sexual games when they were very young—like play doctor, or "I'll show you mine if you'll show me yours." Do you remember any experiences like that when you were growing up?
- Many adolescents are introduced to masturbation by friends or by older children who demonstrate how to do it. How did you first learn about masturbation? Did you have any experience with other people or was it always by yourself?
- Can you remember a time when you were approached by a homosexual? Most people have been at one time or another. How did you react? Was it a good experience for you, or bad?

Often it is helpful to pose theoretical questions to get an idea of the patient's feeling about sexual issues including homosexuality. These can be phrased in two series (for convenience I will phrase them as if to a husband):

What do you suppose your wife would think (feel, do) if she found out you . . . ? What would you think (do, feel) if you found out your wife . . .

had a homosexual experience in the past?
is actively homosexual now?
has had an extramarital sexual affair?
wanted to have anal sex?
wanted to be tied up during sex?

wanted to swap partners with another couple?
wanted to be spanked during sex?
had to have a breast removed?

An infinite number of variations can be used to explore other sexual attitudes and feelings.

When a homosexual person or couple presents with a relationship issue or sexual dysfunction problem, the physician's history and therapy are essentially the same as for a heterosexual couple.

Sexual History Taking When the Initial Complaint Is Not Specifically Sexual

The Female

Among female patients there are two points in history taking that provide easy access to sexual history. These are: (1) menstrual history, which leads naturally into coital and reproductive history; and (2) family history, which leads naturally into parental and sibling relationships; relations with the same-sex and opposite-sex peers; and dating, courting, and petting history.

Either or both of these approaches can be used comfortably by the physician, but the menstrual history approach is more appropriate in a health survey situation.

In the following, the essential survey-type questions of the female sexual function history (as distinct from the routine gynecology–obstetric history) are marked by an asterisk. They are designed to assess the patient's sexual function and level of satisfaction at the present time.

MENSTRUAL HISTORY APPROACH

- When was your last period?
- How many days did it last?
- Do you use tampons or pads?
- How many times did you change tampons on the heaviest day?
- Was that a normal period?
- When was the last period before that?
- Was it about like your most recent period?
- How often do your periods usually come?
- Do you ever miss periods?
- Do your breasts bother you before or during a period?
- Do you have any pain or discomfort during your period?
- How old were you when you had your first period?
- Did your mother or anyone else explain about periods to you?
- During the first year or so after your periods began, did they bother you in any way?
- How old were you when you stopped growing taller?
- How old were you when you began to grow breasts, hips, pubic hair?
- Do you remember how you felt about going through the changes of puberty? Was that an easy or a difficult time for you?
- Do you remember how old you were when you had intercourse for the first time?
- What were the circumstances?
  *Are you having intercourse now? (See section on frequency of intercourse)
  *About how often? (per month, or per week)
  *Is that an increase or decrease from previous years?
  *Do you have pain or discomfort when you have intercourse? (See section on dyspareunia and vaginismus)
  *Is intercourse pleasurable for you?
  *Are you having orgasms? Do you reach a climax? Can you come? (See section on anorgasmia)
  *About what percent of the time do you have orgasm?
  *Are you satisfied with intercourse the way it is for you now?
  *Do you think your partner is satisfied with intercourse the way it is now?
- Do you want to become pregnant now?
- What are you using to keep from getting pregnant? (This leads into a contraceptive and reproductive history.)

The Male

Obtaining a sexual history from males is somewhat less complex than the same task from females in spite of the fact that males are no less anxious about sexual matters and, in many cases, seem to be even more so than females. Most females have had some experience with physician-asked sexual questions related to menstruation and pregnancy. Most males have never been asked by a physician to describe their sexual functioning in any way. In addition, many if not most males in American culture are performance oriented and concerned lest they be sexually judged and found wanting. Women tend to be much more open and matter-of-fact about sexual feelings and gratification. Men tend to be more open about techniques and mechanics of sexual expression.

The technique of psychosocial history taking from men does not differ greatly from that of women, and questions are generally equally applicable. Specific coital history can begin within the genitourinary portion of systems review:

- Are you having sexual intercourse now? (See section on frequency of intercourse)
- About how often do you have intercourse (per week or per month)?
- Is that an increase or a decrease from previous years?
- What do you think has brought about a change in the frequency of intercourse?
- At the present time, do you ever have any difficulty in getting an erection when you want it? (See section on erective difficulty)
- Have you ever had that problem in the past?
- Have you ever had a problem of coming too soon (ejaculating) before you wanted to? (See section on premature ejaculation)
- Is that a problem for you now?
- Was it ever a problem when you were a young man?
- Do you ever find that your erection is all right but you are unable to come—to ejaculate?
- Have you noticed any changes in your sexual feelings or your sexual functions recently?
- If so, can you tell me about that?
- Are you satisfied with your sexual functioning (your sex life) the way it is now?
- Do you think that your partner is satisfied with things the way they are now?

Sexual History Taking When the Initial Complaint Is Specifically Sexual

Annon (1974) has described a sexual problem history format divided into five parts:

1. Description of the problem in the patient's own terms as much as possible. Clarify words and sexual terms used.
2. Onset and cause of the problem. What were the time and situation in which the problem began? What has the course of the problem been; that is, what has happened over time?
3. Patient's assessment of the cause. May be of great help in defining emotional response and attitudes of the patient to his problem. Avoid questions that include "Why?" since these tend to make people defensive.
4. Past attempts at resolution. Professional as well as personal attempts. Books read, nonprofessional advice received, the patient's own strategy. What has been the outcome of these attempts?
5. Goals of the patient. What does the patient want? Patient goals may be far different than the therapist imagines. Does he or she want to save the marriage, reverse the symptoms, absolve himself or herself of responsibility, punish the partner, provide data for separation or divorce, get permission for extramarital experiences? Is the goal that of the patient or of the patient's partner? Is the goal to feel "normal" or "average"?

When sexual partners are seen together, each will have a different viewpoint of the problem, its onset and course, its cause, attempts at resolution, and goals. Goals, particularly, may be quite different, with as many as six different goals involved at the same time:

Partner A goal for self

Partner A goal for partner B

Partner A goal for relationship

Partner B goal for self

Partner B goal for partner A

Partner B goal for relationship

When the patient is seen alone but presents a problem he or she perceives as primarily that of the partner, then history taking is distorted in another way. As the patient's insight into the problem changes, so does the history. The examiner must at all times remember that the history taken is one of both facts and feeling and that feelings are equally important.

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Frequency of Intercourse

Definition

There is no "normal" frequency of intercourse, but changes in coital frequency are of great significance in evaluating health and sexual function.

Technique

Begin by asking: "Do you have a sexual partner now? Tell me something about your partner." If the patient has a partner, ask: "About how often are you having intercourse? per week or per month? Has there been any significant change in your frequency of intercourse in the last several years? If so, can you give me any idea as to why it has decreased (increased)?" Reasons for change may include either patient or partner factors, or both. Such things as illness, physical separation, depression, alienation, sexual boredom, fatigue, work or household pressures, and fears of conception may be given as reasons for decrease. Such things as improved interpersonal relationships, relief from fear of pregnancy, a new partner, or regained health may be given as reasons for increased frequency.

If the patient responds negatively to the question of sexual intercourse, determine whether this absence of sexual activity with a partner is a change from previous habits or has been a lifelong habit. If a lifelong habit, it should be determined if this has been a voluntary choice or has been the result of other factors. Similarly, if celibacy is a change for this patient, some inquiry should be made as to the reason or reasons. The death or serious illness of a partner, divorce, separation, prolonged sexual dysfunction, or emotional incompatibility may be given as an explanation of sexual abstinence.

Basic Science

Age and marital status should not be used as indicators of whether or not a patient is sexually active with a partner (partners). Sexual intercourse (implying penile–vaginal sexual connection) may not always be the most appropriate or exact term to use in order to describe an interpersonal sexual relationship. A patient may have had heterosexual and/or homosexual relationships that include oral, manual, and instrumental sexual manipulation and orgasm, or penile–anal penetration and, at least technically, still not have had intercourse. Most patients in a nonjudgmental setting do not quibble to that extreme and respond to questions about sexual experiences fairly readily and quite frankly. Never make the mistake of assuming that elderly, ill, or disabled patients are not sexually active.

The frequency of sexual intercourse varies according to opportunity, attitude, health, and age. Coital frequency in

marriage decreases fairly rapidly with advancing age but in many couples, coitus persists well into the seventies and eighties.

Clinical Significance

It is a mistake to allow patients to feel that you regard them as abnormal or atypical in coital frequency. Couples who regularly have coitus several times per day may be as normal as couples who seek sexual connection only every few months.

The biological capacity of women for sexual intercourse and orgasm is far greater than that of men. Her capacity for multiple (read "unlimited numbers of") orgasms is well documented. The male's capacity for coitus leading to orgasm and ejaculation is limited by the "refractory period." Although young men sometimes can have repeated orgasms at a single sitting, there is, in general, a postorgasmic period in males during which it is first difficult to develop an erection and later, after erection is possible, difficult to ejaculate. This period of time varies from minutes in younger men to one or several days in aging men. Elongation of the refractory period is a normal part of the male aging process just as increased time to attain erection, decreased firmness of erection, and reduced force of ejaculation are. None of the above is a sign of impending impotence in the aging man. Just as it takes the aging man longer to walk around the block than it did in his 20s, so is the physical evidence of his sexual arousal somewhat delayed. It is no less pleasurable or gratifying.

Aging in women results in some reduction in vaginal lubrication and thinning of vaginal mucosa but does not ordinarily decrease capacity for sexual performance unless postmenopausal vaginal atrophy has occurred.

The maintenance of an active partner-oriented sexual life into advancing age depends on three factors for men:

1. An interested and interesting partner
2. A reasonably good state of general health
3. Continuance of sexual activity without interruption

An aging man whose opportunity for partner sexual relations is interrupted by separation or partner death or by illness in himself or his partner for a period of months may lose his ability to develop and maintain an erection sufficient to effect satisfactory penetration. This is a disuse phenomenon and may be roughly compared to the athlete who drops out of training. When exercise is resumed, the athlete may have a significant reduction in ability to perform. In the case of the aging man, retraining may, but sometimes does not, result in return of erective capacity.

Maintenance of active coitus in the aging woman depends on:

1. The availability of a male partner with the physical ability to perform
2. An interested and interesting partner
3. A reasonably good state of health
4. An estrogenized vaginal epithelium
5. Sufficient natural or artificial lubricant (water-soluble surgical lubricant, moisturizing nonalcoholic skin lotion, saliva)

Patients who have a single sexual partner have less risk of venereal disease but should not be regarded as having no risk. Any patient who describes more than one sexual partner is without question a high-risk candidate for venereal diseases. The risk is based not only on the increase in partners per se but also on the fact that patients who accept short-term partners are accepting individuals who are likely themselves to have had multiple previous short-term partners and are therefore more likely to have become infected.

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Masturbation

Definition

Masturbation is the induction of sexually pleasurable sensations in self or another person by means of physical or psychic stimuli, usually deliberate. It is often, but not necessarily, carried to the point of orgasm. Synonyms include autoeroticism, onanism, self-gratification, self-abuse, jacking-off, and a host of other slang terms. When performed by partners upon each other, it is called *mutual masturbation.* Masturbation implies something other than genital-to-genital contact.

The sensory stimuli can be tactile, thermal, visual, auditory, gustatory, proprioceptive, and olfactory. The psychic stimuli often involve dream, fantasy, and memory.

Technique

Until recently, active self-induction of sexual pleasure was so heavily discouraged by persons in positions of authority that many individuals feel great guilt and perceive masturbation as a problem, a weakness, or a perversity. Masturbation in one form or another is an almost universal activity among men and is probably equally so among women.

While taking a history of masturbation, the physician should be nonthreatening, accepting, reassuring, and permission giving. The following questions should be asked of men: When did you first learn about masturbation? During your high school and college years, did you have other sexual outlets besides masturbation? Since your marriage,

has your frequency of masturbation increased, decreased, or stayed about the same? Approximately how often are you masturbating to orgasm at the present time?

For women, self-masturbation is even more guilt-laden than for males, since traditionally in American culture women have had less freedom to express their sexuality. As a consequence, some women avoid direct and obvious self-stimulation (i.e., genital stroking) but still make heavy use of sensuous fabrics, scents, lotions, touch, massage, light or loose clothing, and daydreams for self-gratification and to excite others sexually. Some women may be reluctant to identify these as masturbatory activities but will readily admit that such stimuli are sensually pleasurable and enjoyed.

Direct sexual self-stimulation is nevertheless common among women. When problems of sexual functioning are present, data on masturbation are an essential part of the history. Questioning should proceed from the more general toward the specific: Can you describe for me situations that you find particularly pleasurable in a physical sense—things that feel good to your body?

Often the patient is uncertain or reluctant to offer anything. Examples such as a long, hot both, a steak dinner with wine, the use of bath powder or body lotion, and backrubs can be suggested by the physician as sensual experiences, and the patient is encouraged to think in terms of body pleasures. What kinds of things can you think of that make you feel sexually exciting or excited?

Some people can have orgasms during sexual daydreams or fantasies: Do you remember having had fantasies or daydreams that made you become excited? Have you ever had an orgasm while you were dreaming or having a fantasy?

Some women are able to have orgasm just by touching or stroking their breasts: Is touching your breasts sexually exciting for you? Have you ever been able to have orgasm in that way? Have you ever been able to have orgasm by rubbing, touching, or stroking any part of your body? your female organs? your clitoris? Have you ever used an electric vibrator to give you sexual pleasure?

If such a line of questions discloses that the patient regularly or irregularly enjoys self-stimulation, then some questions as to technique should be asked. Many women who masturbate by genital stimulation avoid direct clitoral stroking because the clitoris is exquisitely sensitive. More commonly, a finger alongside the clitoris or on the labia minora is employed. Most women do not employ intravaginal instruments for self-stimulation, although some women whose sexual experiences have all been penis oriented do so.

Basic Science

There is no normal frequency of masturbation for males or females. In males, masturbation, like coitus, is usually followed by a refractory period of variable length depending on age, habit, or strength of sexual stimuli. Masturbatory frequency is likewise dictated by levels of sexual tension, opportunity, absence of distractions, habit, or strength of sexual stimuli. Frequencies varying from several times per day to never are all considered normal.

In females, the absence of a physiologic postorgasmic refractory period increases the possibility of multiple occurrences within a limited time frame. Some women regularly attain more than a dozen self-induced orgasms per day without any known deleterious effect. Among prostitutes, repeated sexual experiences in the course of their work often induce high levels of sexual tension but may not result in multiple orgasms with concomitant relief of pelvic congestion. Relief of pelvic congestion may be subsequently obtained with orgasm by masturbation or by orgasmic coitus with a desired partner. Masturbation to orgasm has also been used by women to relieve the pelvic congestion of menstruation.

During times of sexual activity, women without serious sexual inhibitions rarely reject and almost always encourage direct and indirect sexual stimulation of themselves by an accepted partner and readily stimulate the accepted partner by many of the means at their disposal. Mutual masturbation in some form is therefore so common as to become a rule in satisfactory sexual relationships.

Clinical Significance

A masturbatory history in men is useful under at least four circumstances:

1. To establish that the typical adolescent development of sexual tension and subsequent gratification has developed, and to determine the individual's emotional response to his own emerging overt sexuality
2. To document the patient's continuing ability to attain erection and ejaculation (i.e., absence of structural damage)
3. To give evidence of persisting libido
4. To determine if a postmasturbatory refractory period is contributing to coital erective difficulty or ejaculatory incompetence

Additionally, a masturbatory history may give important insights into the patient's sexual fantasy life.

A masturbatory history in women is also useful for other reasons:

1. To give some indication of a patient's range of sexual experiences and responses
2. To add data about her concepts of sexuality and of herself as a sexual person
3. To give evidence of persisting libido
4. To define some of the specific stimuli the patient finds pleasurable

Encouragement of masturbation in women has been used as a technique by which a previously anorgasmic woman can learn what orgasm is like and what sorts of stimuli she finds most gratifying. By accepting permission to experiment with self-gratification, some anorgasmic women whose prior training and conditioning do not restrict such activity will be able to identify the orgasmic goal they seek. Thereafter, their coital efforts to reach orgasm have the advantage of a clearly defined and experienced goal. The female masturbatory history may therefore give important background information on which to base a future therapy program.

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Premature Ejaculation

Definition

Premature ejaculation is defined as inability of the male to control the ejaculatory process during intravaginal containment long enough to satisfy his female partner in at least 50% of coital opportunities. This definition, patterned after that of Masters and Johnson, breaks down when the female partner is persistently anorgasmic. Premature ejaculation has been variously defined by others as ejaculation after less than 30 seconds of vaginal containment, less than 1 minute, etc. Each definition leaves something to be desired.

Technique

The line of questioning should elicit the problem and the patient's attempts to deal with it. "When you were having intercourse fairly regularly, about how long would it last? How long was it usually from the time you put your penis in until you would climax (come, have orgasm)?" The typical answer for a premature ejaculator is considerably less than 2 minutes unless the patient had a prior orgasm by masturbation or coitus. "Was there ever a time when you climaxed before you got your penis in? Can you tell me about that time, what were the circumstances?" "What's the longest time you could have intercourse without ejaculating? Can you tell me about that?"

"Is your partner able to have orgasm during intercourse? If she can't come during intercourse, do you ever use your hand or mouth or a vibrator to help her come? Is that before or after intercourse?"

"Do you feel that you have any control over when you'll come? Would you like to be able to last longer? Has your partner ever said that she would like intercourse to last longer?" The factor of control is important to introduce, both in terms of history and for future therapy. Characteristically, premature ejaculators describe themselves as lacking control.

"Have you tried anything to make you last longer? What kinds of things have you tried?" Premature ejaculators usually attempt a variety of strategies to delay ejaculation. These range from intellectual distraction and self-induced pain to topical anesthetic agents. Other destructive strategies include deliberately avoiding foreplay to reduce levels of sexual excitation, avoiding touch by the partner, reduced vigor of thrusting during coitus. The female partner often retaliates with violent efforts to reach orgasm before her male partner ejaculates. This means that she often attempts to make strong pelvic thrusting movements while his actions are designed to minimize friction and excitation. Thus both partners have the same goal (prolongation of coitus until both have orgasm) but are trying to achieve this goal by diametrically opposite means. The sexual act is therefore likely to end in failure and frustration.

Basic Science

Couples with the problem of premature ejaculation rarely require detailed questioning to elicit a history. When given a sympathetic and nonjudgmental listener, they will readily relate a history so classic as to be repeated with minimal variations in almost every case. Once the examiner is familiar with the usual sequence of events in a sexual partnership frustrated by premature ejaculation, it requires little perception to recognize the story.

Often the female partner is the complainant. Her complaint usually begins with her dissatisfaction with their usual pattern of lovemaking highlighted by inadequate foreplay, her infrequent orgasm, frequent postcoital pelvic congestion, and increasing frustration. This pattern has led to decreased coital frequency, recrimination, degeneration of their interpersonal relationship, and often the development of secondary impotence on the part of her husband.

The man is most likely to be a complainant if he is college educated. He is more likely to express concern if he feels to some degree responsible for his partner's gratification or lack of it. This seems to be largely a cultural phenomenon.

A decrease in the frequency of coitus significantly increases the severity of premature ejaculation because of increased sexual tension levels. In the same manner, a period of separation or a new or more exciting partner increases the severity of premature ejaculation.

Clinical Significance

Premature ejaculation is certainly the most common male sexual dysfunction. It is most common in young men. As men age, some of those who have had premature ejaculation learn ejaculatory control. The cooperation of a warm, sympathetic partner facilitates this learning process.

A man with pronounced premature ejaculation, if sufficiently excited or anxious, may ejaculate at the sight, sound, or touch of a woman. Sometimes, in a situation in which sexual performance is expected of him, he may ejaculate at his own touch. Ejaculation has become a reflex phenomenon as voluntary control has been lost or never learned. In terms of the sexual response cycle, excitation leads to ejaculation with a minimal intervening plateau phase.

Premature ejaculators have no specific personality type or psychic pathology. Classical psychoanalysis as a therapy for premature ejaculation is reported by Helen Singer Kaplan to be minimally successful, although other forms of psychotherapy may be useful in helping the premature ejaculator cope with the emotional problems engendered by his dysfunction. Premature ejaculation is believed to be a learned response and is therefore treated in uncomplicated cases by retraining for ejaculatory control.

Premature ejaculators fall into two major groups. Those born before 1930 or so often had their early sexual experiences with prostitutes. In this setting, sexual performance is male-gratification-oriented, and the customer who performs quickly wins approval from the prostitute and her other clients. Among men born after 1930, early experiences were less often with prostitutes, but were commonly enacted in situations where urgency and risk of discovery and disapproval from authorities were important (drive-in movies, automobile back seats, living room sofas). Again, sexual experiences were primarily male-gratification-oriented, and couples encouraged themselves to perform quickly.

In addition, men with premature ejaculation commonly have a history of premarital petting to orgasm by rubbing against their partner while fully clothed and of the use of

coitus interruptus as a form of contraception; again, these are male-gratification situations.

Not uncommonly, the man with premature ejaculation presents with a complaint of secondary impotence. The experience of being unable to exert ejaculatory control, repeated frustrating coitus, an unhappy complaining wife, reduced sexual stimuli, and a degenerating marital relationship all contribute to a sense of sexual and marital inadequacy. The most common sexual counseling situation encountered is that of an anorgasmic wife with a premature ejaculator husband who may or may not be secondarily impotent.

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Ejaculatory Incompetence

Definition

Inability to ejaculate after achieving erection is termed *ejaculatory incompetence.*

Technique

Begin by asking: Do you ever find that your erection is all right but you are unable to come—to ejaculate? When did you first notice that? Does it happen all the time or just sometimes? Have you noticed any relationship to how long it has been since the last time you ejaculated? Are you taking any drugs or medicines at the present time that you started before this problem began? Can you remember anything going on in your marriage—any problem that began about the same time as this problem?

Basic Science

Ejaculatory incompetence is regarded by many as a form of impotence. Ejaculation is brought about by both the sympathetic and parasympathetic nervous systems. The ejaculatory center is probably located in the lumbar region of the spinal cord. Initially, the sympathetic division causes muscle contractions that deliver the semen to the urethra. Then the parasympathetic system causes clonic spasms of the muscles surrounding the urethra with subsequent expulsion of the fluid.

Clinical Significance

Ejaculatory incompetence is relatively uncommon but has been described under several circumstances:

- As a part of the male refractory period. After male orgasm and ejaculation occur, there is a period of time when it is difficult for a man to regain an erection. After erection is attainable, there is a second phase during which ejaculation is difficult or impossible and requires very prolonged penile stroking. With advancing age, the second phase lengthens in time.
- With advancing age, the need to end coitus with ejaculation decreases. The patient may interpret this as failing powers or impending impotence when it is simply a change due to aging, which diminishes gratification very little.
- The same general categories of pharmacologic agents that may contribute to erective difficulty may in some cases retard ejaculation.
- Some men who consciously restrain ejaculation for a period of time (to avoid conception, or for other reasons) may retrain themselves and thereafter have difficulty ejaculating when they wish to do so.
- Occasionally, emotionally traumatic events (discovery by children, discovery by the sexual partner's husband) have been reported to inhibit the subsequent ability to ejaculate.

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Erectile Difficulty (Impotence)

Definition

Erectile difficulty is the inability to develop or sustain a penile erection for sufficient time to accomplish sexual connection and ejaculation. The term *impotence,* like *frigidity,* is judgmental and disparaging and probably should be avoided by physicians. It is, however, in common usage.

True impotence is classified as primary or secondary, psychic or physical. *Primary impotence* is failure to have ever sustained penile erection for a time sufficient to accomplish

intromission, whether the partner is male or female and whether the orifice is vagina, mouth, or anus. *Secondary impotence* is the failure to accomplish erection sufficient for penile intromission for at least 75% of sexual opportunities, regardless of the partner's sex or the orifice (assumes at least one successful previous intromission).

The ability to masturbate successfully, have nocturnal emissions, and have morning erections does not invalidate the diagnose of impotence or erectile difficulty. These abilities commonly persist in psychogenic impotence and often disappear in organic impotence.

Technique

Ask: At the present time, do you ever have any difficulty in getting an erection when you want it? If so, when? Have you ever had this happen in the past?

If the patient answers affirmatively, a series of questions should be asked to define the circumstances under which erectile difficulties occur:

- How often do you have difficulty with erections?
- Do you tend to lose an erection too soon or is it difficult to get an erection from the beginning?
- How long have you noticed this?
- Does it occur each time you want to have intercourse or is it just sometimes?
- Does the problem seem to be getting worse, better, or staying the same?
- Do you have difficulty getting an erection when you masturbate, or is it only when you are about to have intercourse?
- Do you ever wake up in the morning with an erection?
- Have you noticed any change in your interest in or your reaction to sexual thoughts or to sexy books or pictures?
- Can you remember the first time you ever noticed any difficulty with erections? At that time, what else was happening in your life, at work, or in your marriage?
- Are you taking any drugs or medicines regularly? Do you use any drugs from time to time? pot, speed, LSD, or anything?
- Can you give me an idea about how much alcohol you ordinarily drink in a week's time?
- When would you say was the last time that you had too much to drink?
- What kind of an effect has this difficulty with erections had on your marriage (with your social life)?

Physical causes of secondary impotence fall into three major categories:

- *General debilitating diseases.* Men who are seriously ill or debilitated may lose the ability to develop or sustain erections.
- What kind of a reaction did your partner (wife) have to this problem? How did you feel about that? How have things been between the two of you lately?

Basic Science

Inability to achieve and sustain penile erection under appropriate circumstances or when desired by the patient is an important complaint. The physician must indicate to the patient that his complaint is accepted as important while avoiding any suggestion that the nature of the complaint devalues the complainant or that the impotence is "serious." As in all sexual history taking, a matter-of-fact, nonjudgmental approach is both reassuring for the patient and most productive for the physician. Sometimes the questioner finds himself taking a history of male impotence from the involved female partner if she is the presenting complainant. The questions may differ slightly in form but not in content.

The patient's initial complaint of impotence must be evaluated carefully rather than being accepted on face value alone. Not uncommonly, a patient may complain of impotence when the actual problem is one of the following:

- Loss of libido
- Ejaculatory incompetence
- Premature ejaculation
- Disinterest in a partner
- Change in quality or quantity of sexual performance from one level to some lesser level
- Decrease in volume or force of ejaculate
- Increase in the length of the postcoital refractory period
- Sexual exhaustion
- Normal changes of aging
- Unwillingness or inability to meet the sexual needs or desires of a real or proposed partner
- Anxieties about penile size

Examiners must be alert to these possibilities.

Clinical Significance

Probably 90% of impotence has a large psychic component rather than being purely of physical origin. The following points help to differentiate psychic from physical causes.

Psychogenic	*Organic*
Acute onset	Insidious onset
Temporal relationship to specific stress	None
Selective, intermittent, transient	Persistent, progressively worsening
Potential to respond erotically (masturbation, morning erection, erotic desire in sexual situations)	Progressive waning of sexual interest and desire (absence of spontaneous erections and use of other outlets)

- *Neurologic and/or vascular diseases.* Whether these conditions are central or peripheral may have a significant impact on potency.
- *Pharmacologic.* Included particularly are antihypertensive agents, psychotropic drugs, antiulcer therapy, and estrogens.

Some men who consult physicians for psychic erective problems may have had tranquilizers prescribed that potentiate the problem rather than diminish it.

The two most common events related to the development of secondary impotence are episodes of acute alcoholic intoxication and a history of premature ejaculation. Most men have had erectile failure occasionally. It is more often attributable to emotional or intellectual fatigue than to physical fatigue. The typical male response to such an experience is a feeling of regret coupled with self-accepted rationalization of fatigue or distraction as a cause, with no significant threat to future sexual function. The dysfunctional male is apt to view an isolated episode of erectile failure as a portent of future impotence and to begin to respond with high levels of anxiety about his ability to perform. Soon it is performance anxiety and fear of failure that distract him from pleasure and sexual gratification and result in impotence.

In the male virgin who has significant insecurity about his ability to play a male sexual role, intolerable levels of anxiety about his ability to perform may lead to primary impotence. Such insecurity may arise from absence of an adequate male role model, excessive maternal domination, adolescent homosexual experiences, excessive religious orthodoxy, lack of encouragement and reassurance, or previous humiliating experiences.

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Frigidity

Definition

Frigidity is a lay term implying lack of sexual responsiveness. The word *frigid* is usually applied to a woman in a judgmental way by another person. The terms *cold* and *indifferent* are more often applied to men.

Technique

In response to questions about a woman's satisfaction with her own sexuality or her partner's satisfaction, she may indicate that the word frigid has been used to describe her sexual responses and attitudes. Avoid the word frigid. It has no medical meaning and is, moreover, deprecatory and disparaging. If used by the patient, ask instead for a precise description of her complaint: "I don't know what that word means. It means a lot of different things to different people. Can you tell me exactly what frigidity means to you?"

Basic Science

Problems sometimes included within this term are the following:

- Lack of factual knowledge
- Shyness
- Poor body image
- Rejection of an unwanted lover or an unacceptable sexual practice
- Lack of willingness to experiment or try new sexual experiences
- A difference in sexual needs between partners
- Sexual or social inexperience
- Primary anorgasmia
- Secondary anorgasmia
- Situational anorgasmia
- Random anorgasmia
- Anger or failure to communicate with partner, leading to sexual rejection
- Insufficient lubrication
- Dyspareunia
- Vaginismus
- Sexual anesthesia
- Loss of libido
- Fear of pregnancy
- Emotional reaction to a previous rape
- Sexual aversion

The examiner should explore the complaint with the patient and assess how much of the problem is the patient's failure to achieve her own expectations, to achieve her sexual partner's expectations, or to achieve some other authority's expectations. Are the expectations in fact realistic? Does the failure to achieve expectation represent an inability, an unwillingness, a disagreement about goals, an absence of information, or an absence of permission?

The withholding or dispensing of sexual favors or nurturing (tenderness, warmth, touching, cuddling, holding, grooming, caressing) is a traditional barometer of interpersonal closeness and of sexual partners' satisfaction with one another. In a sexual relationship, manipulation of sexual favors is used both to make war and to make peace. Displeasure with a partner's responsiveness leads to anger, frustration, and anxiety. Anger and anxiety often lead to name-calling: thus, "frigidity" or "coldness." Most if not all of the above problems also occur among male partners, and the cold, indifferent, or sexually nonassertive man is a relatively common female complaint.

Women or men can be said to be sexually aversive when they actually avoid sexual expression or experience. Sometimes this avoidance is accompanied by denial of sexual feelings, by anxiety, or by anger. Sexual aversion represents one end of a spectrum of sexual responsiveness. The other extreme is characterized by sexual interest, pleasure, and excitement from sexual gratification. The great majority of men and women are found at the interest, pleasure, and excitement end of the spectrum. Excessive sexual interest

(e.g., "Don Juanism" in men or "nymphomania" in women) is associated with a continuing unsuccessful search for sexual gratification.

It is not known how much natural biological variation in amount of sexual interest exists among human beings. The impact of culture on sexual interest and on the freedom to express sexual feelings is so enormous that most decrease in sexual interest is probably the result of cultural inhibitions. In general, when we (and lower animals as well) enjoy and are gratified by an experience or feeling, we seek to repeat that experience. When an experience or feeling has been painful or frustrating, we seek to avoid it.

Sexual aversion may be a way of life or it may be in response to a situation. The expression of sexual feelings that have been blocked by circumstance or by inhibition may be handled by denial or sublimation, giving the individual a neutral or disinterested (uninvolved) posture. A disinterest or aversion to sexual expression is an important symptom justifying further investigation.

Clinical Significance

Both men and women who are not demonstrative or overtly affectionate may actually yearn for a warmer and more intimate relationship. Often it is found that such individuals lack a satisfactory role model on which to pattern themselves and as a consequence have had no practice or experience in a close and nurturing interpersonal relationship. Sometimes previous sexual or social experiences have been so unsatisfactory that an individual avoids the risk of intimacy in order to avoid the risk of further hurt. The application of a disparaging label further alienates the individual.

Properly defined, the problem can be analyzed for its constituent elements and these, in turn, further explored.

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Anorgasmia

Definition

In women, the inability to achieve orgasm is termed *anorgasmia*. There are three types:

- *Primary anorgasmia:* Never having achieved orgasm under any circumstance, heterosexual or homosexual, with or without a partner.
- *Situational anorgasmia:* Inability to achieve orgasm regularly in one or more desired sexual circumstances, by means of penile, oral, manual, or other stimulation. Such a patient may be orgasmic with masturbation and not with penile–vaginal coitus (or vice versa). She may be orgasmic in a homosexual relationship but not in a heterosexual one (or vice versa).
- *Random anorgasmia:* Ability to respond fully at some times but not at others, in an unpredictable fashion. Many women are orgasmic in only a portion of coital opportunities; however, one woman may be satisfied to be orgasmic in 40% of coital experiences, while another may be frustrated when she achieves orgasm in only 75% of opportunities. Another form of random anorgasmia involves the woman who has been regularly orgasmic in the past and has now ceased to be. This should more properly be called *secondary anorgasmia.*

Technique

After the fact of coitus and the approximate frequency have been described, the examiner can begin to determine patient satisfaction: "Is sexual intercourse pleasurable for you? Do you enjoy it? If not, what do you find unsatisfying about it?"

In addition to anorgasmia, possible answers include coitus being too frequent or too infrequent, insufficient foreplay, pain on penile insertion or deep thrusting, dissatisfaction with the partner, a feeling of being used, too rapid ejaculation, or insufficient closeness and tenderness during the resolution phase of sexual excitement. "Are you having orgasm when you have intercourse? Approximately what percentage of the time? Is that frequency of orgasm satisfactory to you?" Even if the frequency of orgasm is far below 100%, if the patient expresses satisfaction with her present level, then there is usually no need for the physician to pursue the matter further.

If the patient had previously been orgasmic and has now ceased to be, search for a temporal reference and then try to relate important physical, pharmacologic, emotional, social, or interpersonal events: "Do you remember when it began to be hard for you to reach orgasm? Was anything in particular happening in your life along about that time? Did you change birth control methods, get sick, have a serious fight with your husband—anything like that? Do you remember what else was going on in your life at that time?" As in any history taking, it is helpful to ask the patient for her own insights: "Do you have any idea what made it difficult for you to have orgasms along about that time?" Often, when directly asked, patients will volunteer meaningful observations and perceptions that otherwise might be missed.

Basic Science

Orgasms among women vary. One may be a simple physical release no more complicated that that of the typical man. More commonly, it is a physical response prepared by an

elaborate and complex list of sexual values (expectations) that must be met satisfactorily before the woman is fully responsive. Many, if not most, of these sexual values have never been consciously defined by the woman to herself, much less to someone else. Among sex therapists, much history taking is aimed at defining the woman's sexual value system.

Orgasm in men usually occurs rather early in adolescence with so-called wet dreams and masturbation. Among women, even though many sexually exciting experiences (dreams, fantasies, kissing, caressing) may have occurred during adolescence and young adulthood, orgasm has often not occurred. It is common for women to be orgasmic only after coitus has become a well-established pattern. Presumably this is related to acceptance of her sexual role, a sense of comfort and confidence in her partner and in the relationship, as well as some experience and learning on her part.

In a woman who has failed to achieve orgasm within a self-determined expected range of time and experience, an unwarranted lack of self-confidence and doubt about her womanhood sometimes begin to appear. Coupled with this is often confusion about what orgasm is and what it feels like.

Clinical Significance

In American society, orgasm for the man has been a way of keeping score. A man may view his female partner's absence of orgasm (i.e., "success") as a reflection on his ability as a lover. He may react to this with feelings of guilt at having deprived his partner of orgasm or with feelings that there is something wrong with her or the relationship ("she's frigid"). These feelings are an additional burden for the woman and for the relationship to bear.

For a woman to be maximally sexually responsive, her personal sexual values must be met. Most female sexual dysfunctions are related to an unfulfilled or an unrealistic and nonserving sexual value system. The sexual value system is composed of biophysical and psychosocial factors. Biophysical factors include such things as health, fatigue, warmth, comfort, sight, sound, odor, taste, and touch. Psychosocial factors include such things as respect, tenderness, acceptance, anger, approval, disgust, conditioning, and learned values. For example, one woman might find the idea of a sexual relationship with a tall, dark, hairy, bearded, silent stevedore exciting, while another would be unexcited unless her partner was a fair-haired, loquacious, clean-shaven college professor. This, however, is a gross oversimplification of a complex and ever-changing state of conscious and unconscious attitude and need.

Sometimes learned sexual values are nonserving. For example, a young woman may have learned from her mother that all young men are only interested in taking sexual advantage of her. As a consequence, she finds it hard to be trusting and open in social contact with men and loses opportunities to establish a gratifying relationship.

In a woman who is anorgasmic, the examiner must carefully explore sexual values as well as experiences in order to determine which values are unfulfilled, unrealistic, or nonserving. The examiner must also determine how much nonthreatening opportunity to learn to be orgasmic the patient has had. When there is significant pressure on the patient (either self-induced or received from her partner) to be orgasmic and therefore "normal" and "really sexy," it is difficult for her to be fully and unselfconsciously sexually responsive. Her lack of orgasmic response may be self-interpreted as reducing her value as a person and implying that she is less feminine or less of a "real woman" than others. Such feelings may result in both anxiety and depression.

When a woman's regular sexual partner is impotent or ejaculates prematurely, she may react with anger and hostility or with exaggerated self-doubt about her own sexual identity and capacity as a satisfactory sexual partner. Many such women, therefore, become insecure about themselves as well as about their partners. Sometimes women who are anorgasmic deny their own responsibility and ascribe their lack of sexual responsiveness entirely to their partner's inadequacies. To some extent, this may be real, but all persons must accept ultimate responsibility for their own sexual gratification. When patients ascribe all of a sexual problem to their partner and accept no responsibility themselves, then both understanding and solution of the real problem are thwarted.

Many patients, in a conscious or unconscious effort to define which partner is at fault, go outside the marriage (partnership) and try another sexual partner. Sometimes this extramarital sexual relationship serves simply as an experiment designed to clarify who is at fault in the partnership. Sometimes the relationship serves to achieve gratification not found in the marriage. It seldom solves the original problem.

A clear distinction must be made between a gratifying and enjoyable sexual experience and orgasm (which is only one form of sexual gratification). Many women report that sexual intercourse may be pleasurable, enjoyable, desired, and gratifying even when no orgasm occurs. Orgasm provides dramatic and sudden relief from sexual tension, myotonia, and vascular engorgement, but nonorgasmic coitus at lesser levels of sexual tension may still provide opportunities for closeness, tenderness, excitement, touching, holding, and caressing that are significantly rewarding. When sexual tension is close to orgasmic levels but orgasm is not obtained, unrelieved pelvic vascular engorgement often leads to prolonged pelvic congestion. Congestion plus unfulfilled expectations for orgasmic release and pleasure make the coital experience frustrating. Even if orgasm has been achieved, the coital experience may be unsatisfying if the patient's expectations for tenderness and foreplay were not met.

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Dyspareunia and Vaginismus

Definition

Dyspareunia is painful or uncomfortable sexual intercourse. The term is usually applied to women, although under some circumstances intercourse may be painful for men.

Vaginismus is one cause of dyspareunia. *Vaginismus* is an involuntary spastic contraction of the muscles of the perineum. This results in temporary narrowing of the vaginal opening and pain on attempted insertion of an object into the vagina. In susceptible individuals, the involuntary contraction is precipitated by any real or threatened vaginal invasion and is relieved by cessation of attempted invasion.

Technique

Ask: "Do you ever have pain or discomfort when you have sexual intercourse?" If the answer is yes, try to establish a temporal relationship. "Is that a problem for you now? Does it bother you all the time or just sometimes? Under what circumstances did you have pain? Was it only in a particular position or at a particular time of the month (your menstrual cycle)? What makes the pain worse? Is there anything you or your partner can do to avoid it or make it better? Has it ever made you stop having intercourse or made you avoid intercourse?"

"Does it hurt when you first start (when he first puts his penis in, when the penis is being inserted) or is it a pain that you feel on deep thrusting (when he pushes deep inside you, when he hits something inside)?" This is a critical question because it helps to differentiate problems of superficial penetration (such as vaginismus, too rigid a hymen, absence of lubrication, atrophic vaginal epithelium, vaginitis, or introital scarring) from problems of deep penetration (such as a prolapsed ovary in the cul de sac, pelvic inflammatory disease, endometriosis, retroverted uterus, pelvic peritonitis, or universal joint syndrome).

Questions of lubrication can be resolved by asking: "Do you find that you lubricate (get wet) easily when you get sexually excited? Do you ever seem to be too dry? Does dryness seem to be part of the problem? Have you used any kind of artificial lubricant?" Lack of lubrication may be secondary to dyspareunia, since repeated pain on attempted intercourse interferes with sexual excitement and lubrication. Even when no organic cause for dyspareunia exists, absence of sufficient sexual excitement at the initiation of penile thrusting results in deficient lubrication that causes pain, thereby decreasing excitement and lubrication further. A vicious cycle is set up. Absence of sufficient excitement also sometimes causes pain on deep penetration because the upper vagina does not undergo its characteristic ballooning.

Atrophic vaginitis as a cause of dyspareunia occurs in women who have been surgically castrated or who are postmenopausal and have no estrogen supplementation to restore the vaginal epithelium to its normal thick, resilient status. "How long has it been since you had a menstrual period? Have you been given any hormone treatment since your surgery (since your periods stopped)?"

"Do you have any pain or discomfort that lasts after intercourse is finished or does it quit hurting as soon as you stop? Do you have any discharge, burning, or itching around your vulva (privates, female organs)? Do you seem to be swollen?"

When pain is only on deep penetration and is random rather than frequent or consistent, it suggests that the penis has thrust against an ovary temporarily lodged in the cul de sac. When pain is consistent in coital positions of deep penetration, questions related to deep pelvic pathology arise.

Basic Science

Pain on intercourse should be considered organic until proven otherwise. It cannot be evaluated without a concomitant physical examination. The examiner should attempt to reproduce the patient's pain during the examination. Often it is precisely located, and a specific site can be identified exactly.

The examiner's willingness to accept the pain source as physical is very reassuring to the patient, who will often then freely describe the psychic overlay which makes her dyspareunia so troublesome. The psychophysiologic interplay between pain, sexual excitement, and lubrication can then be easily explored by the patient and physician together. Dyspareunia is a situation in which history taking, examination, reassurance, patient education, and specific treatment proceed so rapidly and are so intermingled that it is difficult to separate them.

Clinical Significance

An excessively large male organ is rarely a cause for dyspareunia. In the presence of adequate levels of sexual excitement, the mature vagina dilates in depth and diameter to accommodate almost any erect penis. The presence of an object (penis, finger) in the vagina further increases vaginal capacity. An excessively long penis increases the possible length of stroke, but as penile length increases, rigidity decreases somewhat and the penis becomes more limber. This may be a disadvantage, since the shaft may bend in the midst of thrusting.

Coital vaginal lacerations both anterior and posterior to the cervix in the vaginal fornices have been described, and rarely such a patient may present to the emergency room with vaginal bleeding. It is my personal impression that these are more often due to excessive coital vigor than to excessive penile length. In such cases, the use of foreign objects in the vagina must be ruled out.

The normal premenopausal vagina in a sexually excited adult woman is a resilient structure and (with the exception of occasional minor superficial mucosal tears) not easily damaged by a wide range of sexual experiences. Pain on intercourse, therefore, suggests that some other nonphysiologic process is under way.

It is often possible to relieve dyspareunia on deep penetration by a change in coital position if the primary cause of pain seems temporarily or permanently inaccessible. After some experimentation early in the relationship, most couples adopt two or perhaps three coital positions as their usual pattern and seldom experiment much more. The most commonly used position (man above woman, female thighs flexed) allows deep penile penetration and increases the

chance of pain in unsusceptible individuals. Often a simple position change (woman supine, thighs extended and together with man's thighs outside; or woman above) will alter the relationship enough to relieve pain on deep penetration.

The following differential diagnosis is useful when interviewing a patient with pain on coitus:

- Vaginismus
- Rigid hymen
- Recently lacerated hymen
- Perineal scarring (episiotomy, trauma)
- Bartholin abscess or cyst
- Vaginitis
- Vulvitis
- Atrophic vaginitis
- Direct clitoral manipulation
- Inadequate lubrication
- Allergic or topical sensitivity reaction
- Radiation vaginitis
- Traumatic lacerations of uterine supports
- Pelvic inflammatory disease and/or abscess
- Endometriosis
- Postsurgical
- Prolapsed ovary

Vaginismus is commonly encountered in the gynecologic examining room when a young, inexperienced, frightened, or previously traumatized woman is approached for examination. Her typical response to the approach of an examining finger is to pull her knees together, lift her hips, slide to the upper end of the examining table, and cry out in alarm. Even when the patient has been reassured and intellectually accepts the idea of pelvic examination, she may not have mastered the painful involuntary spastic contraction of superficial perineal muscles. Usually recognition and acceptance of her vaginismus on the part of the examiner coupled with reassurance and a nonforcing attitude will help the patient regain voluntary control of her perineal muscles.

Vaginismus is one important cause of unconsummated marriage (other causes include primary impotence, imperforate hymen, and vaginal atresia). The response of a frightened, inexperienced, fatigued virginal bride to an assertive but inexperienced and anxious groom may be similar to the above experience in the gynecologist's examining room. Fortunately, in most cases, rest, increasing self-confidence, some patience, and a natural buildup of sexual excitement combine to make most young brides both physically and intellectually enthusiastic for coitus. In a small minority, initially painful attempts at coitus are so discouraging that physician assistance will be necessary.

Coital vaginismus is also seen among unmarried young women who are beginning coitus. In my experience, a suggestion of some previous physician that the patient's vagina may be narrow or small often has reinforced her belief that coitus will be painful or impossible. This is usually the result of a previous physician's failure to recognize vaginismus in the examining room or failure to allow for the reduced caliber of the virgin vagina. Many unnecessary hymenectomies are performed for unrecognized vaginismus.

Young women with vaginismus often have a history of inability to insert vaginal tampons and often have never inspected their own vulva with a mirror or never inserted a finger in their own vaginas.

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